		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026773

Facility Name: St Clair County SLC

Address: 1450 Caseyville Avenue (Number) Swansea (City) 62226 (Zip Code)

County: St. Clair

Telephone Number: 618-277-7730 **Fax #** 618-277-5423

IDPA ID Number: 37-1089886002

Date of Initial License for Current Owners: 01/01/82

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501C3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Nancy Montague **Telephone Number:** 618-277-7730

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Chad M. Rollins
(Title) Executive Director

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	100	Intermediate/DD	100	36,500	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	29,460			29,460	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,460			29,460	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.71%

D. How many bed-hold days during this year were paid by Public Aid?
204 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2001 Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Clair County SLC # 0026773 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	188,670	15,452	11,510	215,632		215,632		215,632			1
2	Food Purchase		144,570		144,570		144,570		144,570			2
3	Housekeeping	78,768	20,341	9,236	108,345		108,345		108,345			3
4	Laundry		1,872	23,900	25,772		25,772		25,772			4
5	Heat and Other Utilities			116,533	116,533		116,533		116,533			5
6	Maintenance	62,756	15,642	5,334	83,732		83,732		83,732			6
7	Other (specify):*											7
8	**TOTAL General Services**	330,194	197,877	166,513	694,584		694,584		694,584			8
	B. Health Care and Programs											
9	Medical Director			5,600	5,600		5,600		5,600			9
10	Nursing and Medical Records	1,587,300	37,389	63,159	1,687,848		1,687,848		1,687,848			10
10a	Therapy	20,223			20,223		20,223		20,223			10a
11	Activities	43,306	6,295		49,601		49,601		49,601			11
12	Social Services	22,094		1,440	23,534		23,534		23,534			12
13	Nurse Aide Training	33,750			33,750		33,750		33,750			13
14	Program Transportation		6,287	2,363	8,650		8,650		8,650			14
15	Other (specify):*	8,688	1,304		9,992		9,992		9,992			15
16	**TOTAL Health Care and Programs**	1,715,361	51,275	72,562	1,839,198		1,839,198		1,839,198			16
	C. General Administration											
17	Administrative	60,280		1,206	61,486		61,486	(1,206)	60,280			17
18	Directors Fees											18
19	Professional Services			28,598	28,598		28,598		28,598			19
20	Dues, Fees, Subscriptions & Promotions			13,209	13,209	808	14,017	(1,125)	12,892			20
21	Clerical & General Office Expenses	108,221	12,225	26,723	147,169		147,169		147,169			21
22	Employee Benefits & Payroll Taxes			394,035	394,035	(808)	393,227		393,227			22
23	Inservice Training & Education			1,669	1,669		1,669		1,669			23
24	Travel and Seminar			6,599	6,599		6,599		6,599			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,633	32,633		32,633		32,633			26
27	Other (specify):*											27
28	**TOTAL General Administration**	168,501	12,225	504,672	685,398		685,398	(2,331)	683,067			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,214,056	261,377	743,747	3,219,180		3,219,180	(2,331)	3,216,849			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Clair County SLC #0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			53,242	53,242		53,242		53,242			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			53,242	53,242		53,242		53,242			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			200,604	200,604		200,604		200,604			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			200,604	200,604		200,604		200,604			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,214,056	261,377	997,593	3,473,026		3,473,026	(2,331)	3,470,695			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	1,206	C17		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	1,125	C20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 2,331		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 2,331		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule N/A					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St Clair County SLC

ID# 0026773

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Clair County SLC # 0026773 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number St Clair County SLC **#** 0026773 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		H.O.M.E. #2	Fairview Heights,	SLC Enrichment Center	Swansea,	To provide recreational opportunities to severe and profou mentally disabled individuals.
		H.O.M.E. #1	Swansea,			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8					N/A						8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11					N/A					11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6							N/A					6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Clair County SLC COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0026773

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,317 B. General Construction Type: Exterior Brick/Frame Frame Protected Non-Combu Number of Stories Single Story

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

SLC-Enrichment Center - To provide recreational opportunities to severe and profound velopmentally disabled individuals.

This is a Gymnasium - (with no beds)

Square Footage - 7528

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care		1979	$ 999	1
2					2
3	TOTALS			$ 999	3

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1984	1984	$ 303,400	$ 10,113	30	$ 10,113	$	$ 172,774	4
5			1984	1984	33,537		15			33,537	5
6											6
7											7
8											8
	Improvement Type**										
9	Building			1978	17,185		15			17,185	9
10	Vaious Improvements			1979	18,581		20			18,581	10
11	Metal Heater Guard-All Pods			1981	5,815		15			5,815	11
12	Sport Court			1982	7,239		10			7,239	12
13	Playground Equipment			1982	10,364		10			10,364	13
14	Storage Building			1982	8,927		15			8,927	14
15	Water Heater-Pod 3			1984	2,065		15			2,065	15
16	Draperies-All Pods & Core Building			1984	22,352		10			22,352	16
17	Drainage System			1984	23,286		10			23,286	17
18	Sidewalk-Core Building to ERC			1984	1,900		10			1,900	18
19	Concrete Sport Court			1984	6,564		10			6,564	19
20	ERC Parking Lot			1984	2,176		10			2,176	20
21	Sidewalk-Core Building to Pod 2 & 3			1984	1,050		10			1,050	21
22	Sidewalk-ERC to Maintenance Building			1985	1,632		10			1,632	22
23	Various Trees			1985	5,600		10			5,600	23
24	Parking Lot-Gravel ERC			1985	1,247		10			1,247	24
25	Asphalt Running Track			1985	8,185		10			8,185	25
26	Door/ERC Building			1985	564	19	30	19		306	26
27	ERC Walk & Curb			1985	3,020		10			3,020	27
28	Pine Pavillon			1985	11,542		15			11,542	28
29	Burglar Alarm			1985	868		15			868	29
30	Gym Divider			1985	1,600		5			1,600	30
31	Storage Shelves-Gym			1985	1,010		5			1,010	31
32	Central Vacuim System-All Buildings			1985	7,680		10			7,680	32
33	Drapes for Core Building			1985	3,031		10			3,031	33
34	Faucets			1985	2,160	108	20	108		1,728	34
35	Power Mixer Valve-Core Building			1985	561		10			561	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Reading Lights-All Pods	1985	$ 1,689	$	10	$	$	$ 1,689	37
38	Light Fixtures-All Pods	1985	145		10			145	38
39	Power Panel/Fire Alarm	1985	1,285	64	20	64		1,029	39
40	Bathroom Fixtures-All Pods	1985	2,050		10			2,050	40
41	Fire Alarm System	1986	4,901	245	20	245		3,819	41
42	Windows-Pod Replacement	1986	244		10			244	42
43	Landscaping	1986	892		10			892	43
44	Power Mixer Valve-Core Building	1986	214		10			214	44
45	Bathroom Vanities-All Pods	1986	465		10			465	45
46	Overhead Basketball Goal	1986	3,422		10			3,422	46
47	Draperies-Core Building (Business Office)	1986	254		10			254	47
48	Redo visitor Room-Core Building	1986	646		10			646	48
49	Light Fixtures-All Pods	1988	1,162		10			1,162	49
50	Heat Booster-Pod 5	1988	712		10			712	50
51	Door Pump/Motor-Core Bldg. Electric Door	1988	858		10			858	51
52	Marble Counter Tops-All Pods	1989	1,818		10			1,818	52
53	Chrome Lava Faucets-All Pods	1989	1,800		10			1,800	53
54	Back Flow Preventor-Core Bldg (Waterlines)	1989	1,293		10			1,293	54
55	Booster Heater-Pod 7	1989	779		10			779	55
56	New Water Heater-Pod 6 (Booster)	1990	760		10			760	56
57	Repair A/C (Core Building)	1990	2,198		5			2,198	57
58	Repair A/C-Pod 5	1990	1,239		5			1,239	58
59	New A/C-Pod 3	1990	3,525		10			3,525	59
60	New Water Heater-Pod 2	1990	1,522		10			1,522	60
61	New Water Heater-Pod 4 (Booster)	1990	760		10			760	61
62	2 Solid Core Doors-Pod 5	1990	619		10			619	62
63	New Water Heater-Pod 6	1990	820		10			820	63
64	New Water Heater-Pod 7	1991	1,592	27	10	27		1,592	64
65	New Water Heater-Pod 3 (Booster)	1991	810	20	10	20		810	65
66	Circuit Breaker Box-Core Building	1991	679	34	10	34		679	66
67	A/C Unit-Compressor Pod 2	1991	975	89	10	89		975	67
68	A/C Unit-Compressor Pod 5	1991	1,285	118	10	118		1,285	68
69	Fire Safety/Smoke Detectors-All Pods	1991	864	79	10	79		864	69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$	$		$	$	$	1
2	A/C Unit-Pod 7 (Unit 2)	1992	3,642	364	10	364		3,521	2
3	A/C Unit-Pod 4 (Unit 1)	1992	3,642	364	10	364		3,521	3
4	Vanities/Pod Bathrooms-All Pods	1992	3,305	331	10	331		3,057	4
5	Rudd Electric Heaters-Pod 2 Booster	1992	810	81	10	81		736	5
6	Water Heaters-Pod 2 & 4	1993	5,491	549	10	549		4,759	6
7	A/C Unit-Pod 2 (Unit 1)	1993	3,642	364	10	364		3,035	7
8	Windows Pod Replacement	1994	400	40	10	40		317	8
9	Painted Pods-Labor/Materials-All Pods	1994	10,644		5			10,644	9
10	Additional Smoke Detectors-All Pods	1994	575	58	10	58		455	10
11	Various Corrections to Code	1994	1,097	110	10	110		859	11
12	Rudd Heater-Pod 5 Booster	1994	860	86	10	86		674	12
13	Rudd Heater-Pod 6	1995	1,950	195	10	195		1,316	13
14	A/C Unit-Pod 6 (Unit 2)	1995	3,953	395	10	395		2,471	14
15	A/C Unit-ERC (Classroom)	1995	1,774	177	10	177		1,109	15
16	New Carpeting-All Pods	1996	38,806	3,234	7	3,234		38,806	16
17	Painted Pods-Labor/Materials-(Touch Up-All Pods)	1996	3,356	280	5	280		3,356	17
18	Water Heaters-Pod 5	1996	2,032	203	10	203		1,084	18
19	Booster Heater-Pod 5	1996	951	95	10	95		507	19
20	Booster Heater (Spare)	1996	952	95	10	95		539	20
21	Carpeting-Core Building	1997	6,041	863	7	863		3,740	21
22	Water Heater Booster-Dietary	1997	1,585	226	7	226		925	22
23	Walk-In Freezer Repair	1998	1,590	227	7	227		833	23
24	Water Heater-120 Gallons	1998	2,152	307	7	307		948	24
25	Water Heater -120 Gallons	2000	2,256	322	7	322		483	25
26	Gymnasium Roof	2000	21,635	1,442	15	1,442		1,563	26
27	Rennovation of Pod 2	2001	66,904	9,558	7	9,558		9,558	27
28	Rennovation of Pod 4	2001	7,746	277	7	277		277	28
29									29
30									30
31	ROUNDING						(3)	(3)	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 753,209	$ 31,159		$ 31,159	$ (3)	$ 521,854	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$	$	$	$		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	1997 Deere Riding Mower	1997	$ 1,000	$ 200	$ 200	$	5	$ 900	76
77	Patient Care	1999 Dodge Mini Van	1999	15,004	3,001	3,001		5	8,752	77
78	Patient Care	2000 Used Riding LawnMower	2001	750	50	50		5	50	78
79								5		79
80	TOTALS			$ 96,913	$ 3,251	$ 3,251	$		$ 89,861	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,258,892	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 53,242	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 53,242	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 961,234	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. 0
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 44

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 86

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)		6,178		6,178
4	Clinical Wages	(b)		12,076		12,076
5	In-House Trainer Wages	(c)	800	3,040		3,840
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 800	$ 21,294	$	$ 22,094
10	SUM OF line 9, col. 1 and 2	(e)	$ 22,094			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	24
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	-5
2. From other facilities (f)	
TOTAL TRAINED	19

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	10.3	visits		116	5,804		116	5,804	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	116	$ 5,804	$	116	$ 5,804	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Clair County SLC # 0026773 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 892,204	$ 892,204	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	534,541	534,541	3
4	Supply Inventory (priced at Cost)	11,103	11,103	4
5	Short-Term Investments			5
6	Prepaid Insurance	9,609	9,609	6
7	Other Prepaid Expenses	3,499	3,499	7
8	Accounts Receivable (owners or related parties)	70,565	70,565	8
9	Other(specify):	1	1	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,521,522	$ 1,521,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	336,937	336,937	14
15	Leasehold Improvements, at Historical Cost	416,271	416,271	15
16	Equipment, at Historical Cost	597,348	597,348	16
17	Accumulated Depreciation (book methods)	(961,234)	(961,234)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 389,322	$ 389,322	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,910,844	$ 1,910,844	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 44,732	$ 44,732	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	280,795	280,795	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	140,701	140,701	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 466,228	$ 466,228	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 466,228	$ 466,228	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,444,616	$ 1,444,616	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,910,844	$ 1,910,844	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,173,182	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,173,182	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	271,434	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 271,434	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,444,616	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,690,506	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,690,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	23,350	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 23,350	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,605	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,605	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,744,461	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	694,584	31
32	Health Care	1,839,198	32
33	General Administration	685,398	33
	B. Capital Expense		
34	Ownership	53,242	34
	C. Ancillary Expense		
35	Special Cost Centers	200,604	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39	ROUNDING	1	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,473,027	40
41	**Income before Income Taxes (line 30 minus line 40)****	271,434	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 271,434	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,133	1,341	$ 23,778	$ 17.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,313	2,903	50,362	17.35	3
4	Licensed Practical Nurses	14,216	13,610	203,932	14.98	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	2,470	2,470	18,254	7.39	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,654	2,000	20,223	10.11	8
9	Activity Director	1,791	2,043	22,577	11.05	9
10	Activity Assistants	1,162	1,289	20,729	16.08	10
11	Social Service Workers	2,363	2,041	20,665	10.12	11
12	Dietician					12
13	Food Service Supervisor	3,926	4,344	50,312	11.58	13
14	Head Cook	6,323	7,471	66,079	8.84	14
15	Cook Helpers/Assistants	589	589	4,761	8.08	15
16	Dishwashers	8,777	9,455	67,518	7.14	16
17	Maintenance Workers	5,543	5,562	62,756	11.28	17
18	Housekeepers	8,958	10,277	78,768	7.66	18
19	Laundry					19
20	Administrator	2,107	2,024	49,810	24.61	20
21	Assistant Administrator	1,682	733	10,470	14.28	21
22	Other Administrative	3,802	4,191	62,110	14.82	22
23	Office Manager	1,742	1,955	31,458	16.09	23
24	Clerical	1,735	1,859	14,654	7.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	7,994	8,930	106,320	11.91	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	122,670	134,479	1,204,336	8.96	30
31	Medical Records		1,242	15,496	12.48	31
32	Other Health Care(specify)					32
33	Other(specify) Seamtress	1,232	1,290	8,688	6.73	33
34	TOTAL (lines 1 - 33)	204,182	222,098	$ 2,214,056 *	$ 9.97	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	224	$ 8,950	1.3	35
36	Medical Director	120	5,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	244	9,764	10.3	38
39	Pharmacist Consultant	72	2,160	10.3	39
40	Physical Therapy Consultant	112	5,575	10.3	40
41	Occupational Therapy Consultant	248	12,400	10.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	104	6,265	10.3	43
44	Activity Consultant				44
45	Social Service Consultant	24	1,440	12.3	45
46	Other(specify) Psychiatrist	48	3,000	10.3	46
47	Psychologist	300	18,191	10.3	47
48	Personnel	36	540	20.3	48
49	TOTAL (lines 35 - 48)	1,532	$ 73,885		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chad M. Rollins	Executive Director	0	$ 49,810
Melissa Sauerwein	Assistant Administrator	0	10,470
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,280

B. Administrative - Other

Description	Amount
Bank Charges	$ 1,206
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,206
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIDC	Payroll Service	$ 3,701
Rice, Sullivan & Co	CPA's	8,253
Blackwell Sanders Peper Martin	Attorneys	5,000
Gallop, Johnson Neuman, LLC,	Attorneys	11,644
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 28,598

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,839
Unemployment Compensation Insurance	13,367
FICA Taxes	163,775
Employee Health Insurance	129,123
Employee Meals	56,623
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	3,928
Employee Gifts	4,380
TOTAL (agree to Schedule V, line 22, col.8)	$ 394,035

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	7,904
Health Care Worker Background Check	808
(Indicate # of checks performed 67)	
Illinois Health Care Asso	4,440
Less: 25.34% Lobbying Costs	(1,125)
Other Professional Dues	281
Licensing Fees	294
News Democrat Subscription	90
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,892

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,599
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,599

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10						N/A							
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Clair County SLC # 0026773 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Asso. $4440**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,852** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **200,604**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **55,615** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **99%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Rice, Sullivan & Company** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.